STATE OF MICHIGAN

DEPARTMENT OF LABOR AND ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 86552-001**

v

Physicians Health Plan of Mid-Michigan
Respondent
_____/

Issued and entered
This 23rd day of January 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On December 3, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL550.1901 *et seq.* On December 10, 2007, after a preliminary review of the material submitted, the Commissioner accepted the request.

The issue in this matter can be determined by analyzing the contract defining the Petitioner's health coverage. The Commissioner reviews contractual issues under MCL 500.1911(7). No medical issues are presented requiring analysis by an independent medical review organization.

II
FACTUAL BACKGROUND

The Petitioner is a member of Physicians Health Plan of Mid-Michigan (PHP). She says that on July 31, 2007, she had a follow-up speech evaluation at the XXXXX and requested coverage from PHP for the service. PHP denied coverage, stating that it only provides benefits

for speech therapy when a speech impediment or speech dysfunction results from injury, stroke, or a congenital anomaly.

The Petitioner appealed the denial through PHP's internal grievance process and PHP issued a final adverse determination dated November 28, 2007.

III
ISSUE

Did PHP correctly deny coverage for the Petitioner's July 31, 2007, services at XXXXX?

IV
ANALYSIS

Petitioner's Argument

The Petitioner initially went to XXXXX for an evaluation of cough and dyspnea. She argues that PHP should cover the services she received at XXXXX on July 31, 2007, because it was follow-up care for services she received on May 14, 2007, that PHP covered. The Petitioner says that the service on July 31, 2007 was an evaluation and not speech therapy and was authorized by PHP. She believes PHP should pay for the July 31, 2007 services as it did for the May 14, 2007 services.

PHP's Argument

In its November 28, 2007, final adverse determination, PHP said that it denied the July 31, 2007, speech therapy visit because, "speech therapy is covered only when the speech impediment or speech dysfunction results from Injury, Stroke or Congenital Anomaly." In support of its decision, PHP cited the following provision in *Section 1: What's Covered – Benefits* of the Petitioner's certificate of coverage (page 33):

> **(26) Rehabilitation Services-Outpatient**
>
> Short-term outpatient rehabilitation services for:
>
> * * *
>
> - Speech therapy (subject to specific restrictions and exclusions).
>
> * * *

> Please note that we will pay Benefits for speech therapy only when the speech impediment or speech dysfunction results from Injury, stroke or a Congenital Anomaly.

PHP argues that the Petitioner does not meet the criteria for coverage quoted above, i.e., her speech dysfunction did not result from an injury, stroke, or congenital anomaly, and therefore the speech therapy on July 31, 2007, was not a covered benefit.

Commissioner's Review

The Commissioner carefully reviewed the arguments and documents the parties submitted. The issue in this case is whether PHP properly denied coverage for the services the Petitioner received on July 31, 2007.

A health maintenance organization (HMO) like PHP is required under Section 3519(3) of the Insurance Code of 1956, MCL 500.3519(3), to provide "basic health services." Speech therapy is not a basic health service as that term is defined in Section 3501(b) of the Insurance Code, MCL 500.3501(b), and HMOs are not required to cover it. HMOs are free to determine whether they will cover speech therapy – they may limit the benefit or totally exclude it from coverage. The Petitioner's benefit plan includes some coverage for speech therapy but PHP limits it to therapy for a speech impediment or speech dysfunction that results from an injury, stroke, or congenital anomaly. Because the record does not establish that the Petitioner requires speech therapy because of an injury, stroke, or congenital anomaly, any speech therapy services she received would be excluded from coverage.

The Petitioner says that she did not have speech therapy services on July 31, 2007; she contends that she only had an evaluation and a laryngoscopy that day. The record shows that the Petitioner had an appointment on July 31, 2007, with XXXXX, speech-language pathologist, to go over the exercises that she had been previously given to help her condition. Claim and billing information in the record indicate that the disputed services were billed under procedure code 92507, "treatment of speech, language, voice, communication, and/or auditory processing

disorder; individual." The record also shows that she had the evaluation on May 14, 2007 (procedure code 92506, "evaluation of speech, language, voice, communication, and/or auditory processing"). If the Petitioner did not have the speech therapy services on July 31, 2007, that were listed by XXXXX she should contact him directly to resolve the issue.

Based on the record, the Commissioner concludes that the Petitioner did not meet the requirements for speech therapy and finds that PHP's final adverse determination is correct.

V
ORDER

PHP's November 28, 2007, final adverse determination is upheld.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.